

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 2331

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

I, CAITLIN ENGLISH, Coroner having investigated the death of ADAM JAMES VINCENT PEARSON

without holding an inquest:

find that the identity of the deceased was ADAM JAMES VINCENT PEARSON

born on 21 March 1981

and the death occurred sometime between 19 May 2013 and 29 May 2013

at Mrs Bon Bay, Lake Eildon, Victoria

from:

1 (a) CONSISTENT WITH DROWNING

Pursuant to section 67(1) of the **Coroners Act 2008**, there is a public interest to be served in making findings with respect to **the following circumstances:**

1. Adam James Vincent Pearson was 32 years of age at the time of his death. He resided in Shepparton with his partner Venessa Pearson and their two daughters. Mr Pearson was a keen and experienced fisherman who would fish at least once a fortnight, often fishing alone in his 4 metre aluminium 'tinnie' boat.¹ Mr Pearson was the Australian representative for Polish fishing lure manufacturer, Salmo, and was a co-sponsor of the 'Central Victorian Lure Casters Super Series' fishing competition.
2. A police investigation was conducted into the circumstances of his death.

¹ Coronial brief, 6.

3. A brief prepared by Victoria Police for the coroner includes statements obtained from Ms Pearson, witnesses, and investigating officers. I have drawn on all of this material as to the factual matters in this finding.

Health History

4. Prior to his death, Mr Pearson was treated by general practitioner Dr Waller at the Princess Park Medical Clinic in Shepparton. Mr Pearson had a history of back pain, the result of a back injury sustained in a motor vehicle accident in 2002. Mr Pearson had surgery on his back in 2003 and 2007. Mr Pearson was prescribed Lyrica 150mg twice daily and Tramal SR 200mg twice daily for his back pain. Dr Waller noted that the medications prescribed were used for analgesia, as Mr Pearson had previous issues with addiction to prescription medication and was not willing to take benzodiazepine or opioid analgesia again.²
5. Ms Pearson recalled Mr Pearson having a fainting episode at home in February 2013, involving him standing after sitting at a table, taking several steps, and then falling over.³ Dr Waller's records indicate that at a consultation on 11 January 2013, Mr Pearson reported a brief loss of consciousness which occurred around Christmas 2012, with a few episodes of light-headedness around that time. Dr Waller completed a history and examination to exclude any significant cause. Mr Pearson had not been eating or drinking well during this period, and Dr Waller concluded that he may have been experiencing postural hypotension or a vaso-vagal episode from the sharp pain in his lower back. He advised Mr Pearson to keep his fluid levels up, and to be cautious with bending over, particularly during warmer weather.⁴
6. Mr Pearson had been suffering from haemorrhoids for some time, and on 7 May 2013 he had undergone surgery for his condition. Following the operation, Mr Pearson improved and Ms Pearson was of the view his pain was diminished.⁵

² Statement of Dr Greg Waller, dated 22 July 2015, 1-2.

³ Statement of Detective Senior Leading Constable Peter Clifford, dated 11 July 2015.

⁴ Above n 2, 1.

⁵ Coronial brief, 7-8.

Events proximate to death

7. On 18 May 2013, Mr Pearson left home alone to go fishing at Lake Eildon, intending to return on the evening of 19 May 2013. At approximately lunch time, Mr Pearson rang the home telephone from his mobile telephone and then hung up, so that Ms Pearson could return the call from the home phone. Mr Pearson would regularly call the home phone in this manner, as he did not have much mobile phone credit. Ms Pearson spoke to Mr Pearson, recalling that he was happy as he had caught two trout and one cod. At approximately 6:50p.m. he called the house phone again and then hung up, and Ms Pearson returned the call from the home phone. Mr Pearson said he was tired and he wanted to get some sleep so he could wake up early and go fishing again. Mr Pearson told Ms Pearson he had got his thermal pants wet and he was going to try and dry them out overnight. Mr Pearson spoke to his daughters, and after approximately half an hour on the phone the conversation ended.⁶
8. On 19 May 2013, at approximately midday Mr Pearson called the home phone from his mobile and hung up, indicating that Ms Pearson should call him back. Ms Pearson called him back and told him she was starting to get worried about him. Mr Pearson told Ms Pearson he had forgotten to call and had only just turned his phone on. He told Ms Pearson he was hungry, asked what was for dinner that night, and told Ms Pearson he would be home just after dark that evening. Ms Pearson took this to mean he would be home at approximately 9:00p.m., as she was aware that he would ordinarily fish until it became dark, remove the boat from the lake, and then drive home to Shepparton. Mr Pearson told Ms Pearson he would call her again as he was leaving Lake Eildon, but Ms Pearson received no further phone calls from Mr Pearson.⁷
9. At approximately 2:30p.m. to 3:00p.m., Adrian Crawford and his son Nick were concluding their day of fishing on Lake Eildon, having launched their boat from the boat ramp at the end of Hutchinsons Road in Bonnie Doon at approximately 10:00a.m. that morning. Upon their return to the boat ramp, Mr Crawford saw a small aluminium boat approximately 100 metres from the lake shore, nosed into a tree. Mr Crawford reported that upon first sight he thought there was no one in the boat. He trailered his boat, and then went with Nick to take another look at the boat but could not see clearly. Mr Crawford took a photograph of a

⁶ Coronial brief, 6.

⁷ Ibid.

vehicle and boat parked near the boat ramp, with the tinnie visible on the water in the background. Mr Crawford and Nick then left the lake and returned home.⁸

10. At 9:30p.m. Mr Pearson had not arrived home, and Ms Pearson called his mobile telephone. The call went straight to voicemail. She thought the call had failed because he would not answer the phone while driving through the hills.
11. Ms Pearson fell asleep, and woke at approximately 12:30a.m. on 20 May 2013. Mr Pearson was still not home, and Ms Pearson felt worried. She continued to call his mobile phone all night, and became worried that perhaps he had fallen overboard from his boat. She occasionally worried about Mr Pearson's safety on the boat, as he would often walk around on the boat barefoot and she felt this was dangerous. Ms Pearson recalled watching the 6:00a.m. news on the television, falling asleep and then waking at 7:30a.m. Mr Pearson had still not returned home. Ms Pearson called her sister-in-law Sarah Kennedy to ask if Dion, Mr Pearson's brother, had heard from him. Ms Kennedy reported they had not heard from Mr Pearson, and encouraged Ms Pearson to contact the police.⁹
12. At approximately 8:15a.m., Senior Sergeant Lyn Holland of the Mansfield Police Station received a telephone call from Ms Pearson reporting Mr Pearson as missing, advising Senior Sergeant Holland that Mr Pearson had been fishing near Bonnie Doon and he had not returned home on 19 May 2013 as expected. Ms Pearson provided details of Mr Pearson's car, boat trailer, and boat, and Senior Sergeant Holland arranged for a police unit to attend the main boat ramp of Bonnie Doon. Officers arrived at the boat ramp at approximately 9:50a.m. but did not find Mr Pearson's car. Senior Sergeant Holland contacted Ms Pearson and advised her of the unsuccessful search.¹⁰
13. Senior Sergeant Daniel Harrop and Leading Senior Constable David Ackland, the Victoria Police officers who were searching for Mr Pearson's car, continued their search at other nearby boat ramps for the car. A short time after leaving the main boat ramp at Bonnie Doon they arrived at the Kennedy Point boat ramp and found Mr Pearson's maroon Mitsubishi Pajero registration YER281 with single axle trailer attached to the vehicle. Senior Sergeant Harrop and Leading Senior Constable Ackland notified police

⁸ Coronial brief, 21.

⁹ Coronial brief, 7.

¹⁰ Coronial brief, 37.

communications, and were instructed to remain with the vehicle until relieved by Leading Senior Constable Johnstone and Leading Senior Constable Mc Hugh.¹¹

14. Senior Sergeant Harrop and Leading Senior Constable Ackland were relieved at approximately 10:30a.m., and were subsequently directed to patrol the foreshore of the lake in the hopes that Mr Pearson was stranded on the lake in his boat. At approximately 10:45a.m., they attended the deep water boat ramp at Hutchinsons Road in Bonnie Doon. Looking out over the water, Senior Sergeant Harrop observed what he initially thought was a tree stump but eventually identified as a small boat after it drifted a short distance. Senior Sergeant Harrop reported that the boat was between 800 metres to 1000 metres away, and it was difficult to see but he could not see anyone in the boat. Senior Sergeant Harrop contacted police communications and informed them of his observations. He then sought assistance from Mark Byball, owner of the nearby Lakeside Caravan Park, to go out on the water to observe the boat.¹²
15. Mr Byball, Senior Sergeant Harrop and Leading Senior Constable Ackland launched onto the lake in Mr Byball's boat, and proceeded to the location where Senior Sergeant Harrop had observed the small boat. At 11:10a.m., Senior Sergeant Harris observed a small aluminium boat registration number HM878 with the words 'Salmo Australia' written on the side. On approach, Senior Sergeant Harrop observed that no one was in the boat. Upon closer inspection, officers found an overturned tackle box in the boat, and numerous other items scattered around the boat floor. Photographs of the boat were taken, and police communications were contacted and notified of the boat's location. The officers were instructed to tow the boat to the boat ramp where Mr Pearson's vehicle had been located. At approximately 12:10p.m., the boat was transferred into the care of Leading Senior Constable Brett Tanian of the water police unit.¹³
16. Leading Senior Constable Tanian observed that the boat was constructed of unpainted aluminium, measuring approximately 4 metres and powered by a 9.9 horsepower Mercury tiller control outboard. He observed that equipment in the vessel was neatly stowed with the exception of a tackle box lying on its side with some of its contents strewn on the floor. A small electric motor in the upwards position was clamped to the port side of the boat. A

¹¹ Coronial brief, 10-11.

¹² Coronial brief, 11.

¹³ Ibid.

further visual examination of the boat revealed a small fuel tank which would ordinarily hold approximately 10 litres of fuel. Leading Senior Constable Tanian observed no evidence of high speed impact marks. He further observed that the 'kill switch' a toggle type switch activated by a lanyard which would stop the engine by pulling on the lanyard, was in 'run mode' with no presence of a lanyard. Leading Senior Constable Tanian noted that the toggle switch could be pushed into the run position without the lanyard being fitted, and the engine would run normally.¹⁴

17. Leading Senior Constable Tanian beached the towed vessel at the Kennedy Point boat ramp, and further observed that the throttle was set at idle and in gear and the fuel tank was empty. A sounder¹⁵ on board was running but was not a combined global positioning system, so Mr Pearson's previous course was unknown. Leading Senior Constable Tanian located Mr Pearson's wallet, photo identification and car keys on board along with his mobile telephone, which had a flat battery. A remote control for a GoPro camera was located near the operator's seat of the boat, but the camera was not located. A fishing rod was located, but the reel contained no fishing line. Further examination of the boat once trailered revealed that the tiller arm was very tight, which would have made steering hard. Leading Senior Constable Tanian reported that the throttle control had been tampered with or modified to assist with maintaining the vessel's speed. No blood, hair or human matter were located anywhere within the vessel, but the boat's foredeck had mud, boot marks and small amounts of bark on it. Three personal flotation devices were found on board, stowed under the foredeck.¹⁶
18. Later that day, Ms Pearson attended the Mansfield Police Station to provide a statement and viewed the vessel. She noted that all three personal flotation devices were on board, being two small jackets for their daughters and a larger jacket for him. Ms Pearson was not aware of Mr Pearson wearing a personal flotation device other than the device on the boat. Ms Pearson indicated that Mr Pearson's favourite fishing rod was missing, and that he would generally cast lures with the rod from the bow of the boat.¹⁷

¹⁴ Coronial brief, 42-44.

¹⁵ A depth sounder commonly used by fisherman to identify where fish may be in the water.

¹⁶ Coronial brief, 38.

¹⁷ Coronial brief, 44.

19. Victoria Police alerted the media to the search for Mr Pearson, which led to a number of calls offering information, namely Mr Crawford and his sighting of an unmanned boat on 19 May 2013. The search for Mr Pearson continued, with Victoria Police and Country Fire Authority officers searching for Mr Pearson from the air and on the water. Friends of Mr Pearson also joined the search, with friend Darren McDonald searching for him on 22 May 2013 and 23 May 2013, and another friend Jeffery Baade searching for him on 25 May 2013.
20. On 29 May 2013, Mr McDonald, Mr Baade, and others went to Lake Eildon to search for Mr Pearson. At approximately 11:15a.m., Mr Baade observed something floating in the water approximately 600 to 700 metres from Hutchinson's Road towards Geelong Hill. Upon closer observation, Mr Baade discovered it was the body of Mr Pearson. Mr Baade called 000 and contacted Mr Brown and Mr McDonald to advise that he had found Mr Pearson.¹⁸
21. Leading Senior Constable Leigh Johnstone attended the scene, and assisted with retrieval of Mr Pearson's body and bringing him ashore.¹⁹

Post Mortem Examination

22. A post mortem examination was conducted by Forensic Pathology Registrar Dr Gregory Young at the Victorian Institute of Forensic Medicine on 4 June 2013. Dr Young formulated the cause of death. I accept his opinion.
23. Toxicological analysis of blood specimens detected ethanol²⁰ (0.01g/100mL), tramadol²¹ (~0.9mg/L), pregabalin²² (~1.4mg/L) and delta-9-tetrahydrocannabinol²³ (detected >100ng/mL). Dr Young reported that tramadol and pregabalin concentrations detected were consistent with therapeutic use. Dr Young further reported that the level of delta-9-

¹⁸ Coronial brief, 24.

¹⁹ Coronial brief, 28-29.

²⁰ Alcohol is the common term for ethanol.

²¹ Tramadol is a narcotic analgesic used for the treatment of moderate to severe pain.

²² Pregabalin, an analog of the inhibitory neurotransmitter gamma-aminobutyric acid, is used clinically as an analgesic, anticonvulsant, and anxiolytic agent. Pregabalin is available in Australia as Lyrica in 25mg, 75mg, 150mg and 300mg capsules.

²³ Delta-9-tetrahydrocannabinol (THC) is the active form of cannabis. Peak blood concentrations following the smoking of standard doses can exceed 100ng/mL. This usually occurs within minutes. Persons under the influence of cannabis will experience impaired cognition (reasoning and thought), poor vigilance, and impaired reaction times and coordination.

tetrahydrocannabinol detected, while allowing for post-mortem redistribution, indicated recent use of cannabis.

Further Investigation

24. The statement of Leading Senior Constable Tanian opined that sometime after 12:04p.m. on 19 May 2013, Mr Pearson was alone in his vessel which was underway. It is likely he was not wearing a personal flotation device, and the engine 'kill switch' was in the run position but was not connected to Mr Pearson by a lanyard. At the time, there was likely a fishing rod over the transom, which was possibly trolling a fishing lure. Mr Pearson was likely using his favourite fishing rod when he, for some unexplained reason, has entered the water. The reason provided by Leading Senior Constable Tanian is that Mr Pearson was most likely standing on the smooth aluminium foredeck of his boat, and has slipped and fallen into the water somewhere in the vicinity of Mrs Bon Bay, south of Bonnie Doon. Once Mr Pearson was in the water, it is possible he removed clothing, but it is unknown if it was an attempt to swim after his vessel which was motoring away or to get himself to the shore. Leading Senior Constable Tanian noted that if the 'kill switch' was being operated appropriately, the engine would have immediately stopped upon Mr Pearson falling into the water. He may have been able to swim to his vessel and reboard it.²⁴
25. A further statement from Sergeant Matt Henderson of the Victoria Police Water Police Squad concurs with Leading Senior Constable Tanian's conclusions in relation to the circumstances of Mr Pearson's death. Sergeant Henderson identified three main causal factors in relation to Mr Pearson's death. Firstly, the outboard motor had been made to operate without a human hand on it at all times, and the motor had been rigged to essentially travel in a straight line if unattended. Sergeant Henderson indicated that vessels of this type would tend to turn one way or another and simply circle should the occupant fall out. Had this occurred, the chances of Mr Pearson reboarding his vessel and/or locating him near his vessel would have dramatically improved. Secondly, Mr Pearson did not appear to be wearing a lifejacket or personal flotation device. Had one been worn, Mr Pearson's chances of survival would likely have increased significantly. Thirdly, had a lanyard been fitted to the motor and connected to Mr Pearson, his fall from the boat would have shut off the boat's

²⁴ Coronial brief, 49-50.

motor. This would have prevented the boat from travelling far after the fall, and Mr Pearson would have had a minimal distance to swim to reboard his vessel.²⁵

Opportunities for prevention

26. Sergeant Adrian Sinclair of the Victoria Police Marine Investigation Unit provided information to the coroner in relation to preventative measures which may assist in prevention of future deaths in similar situations. Sergeant Sinclair indicated that the use of kill switches is taught at boating safety programs, and is mentioned in almost all marine safety literature. Regulation 27 of the *Marine Safety Regulations 2012* (the Regulations) mentions that kill switches must be operable if they are fitted, and provides that the registered operator of the vessel does not allow the vessel to be operated unless it is fit for the purpose. Sergeant Sinclair suggested a recommendation that an Infringement Notice be introduced for a specific offence of failing to correctly use a safety lanyard or kill switch.²⁶
27. I acknowledge Sergeant Sinclair's suggestions for recommendations in relation to introduction of Infringement Notices for a breach of Regulation 27 of the Regulations. Whilst this may be desirable as an immediate sanction and may act as a deterrent, I am not of the view that an Infringement Notice power would have made a difference in this case. Operators can currently be charged under section 31 of the *Maritime Safety Act 2010* (Vic) in relation to a number of safety breaches, including the failure to use a kill switch or lanyard.
28. Sergeant Sinclair expressed concern that the throttle control on Mr Pearson's vehicle had been tampered with or modified so that it would stay fixed at a higher speed even when the operator's hand was removed. Sergeant Sinclair formed the opinion that such a modification made the vessel un-seaworthy and highly unsafe, and compared the modification to driving a car that would not slow down when pressure was taken off the accelerator. Sergeant Sinclair suggested that vessels should undergo mandatory seaworthy inspections at predetermined intervals, and upon acquisition, transfer or modification of a vessel, with such testing to be conducted by an accredited person as determined by the appropriate regulatory authority.²⁷

²⁵ Statement of Sergeant Matt Henderson, dated 28 March 2015, 1-2.

²⁶ Email correspondence of Sergeant Adrian Sinclair, dated 26 June 2015, 1.

²⁷ Ibid, 1-2.

29. I agree with Sergeant Sinclair and refer to my findings in the coronial cases of Kevin Caithness²⁸ and Paul Washington.²⁹ As part of those investigations I received advice from Transport Safety Victoria (TSV) that in mid-2012 it held a workshop examining risks associated with recreational vessel owners undertaking repairs, modifications, and construction on their own vessels. TSV advised that it supported the concept of a vessel inspections regime for second hand vessels, but noted that any mandatory inspections regime *'development and implementation in the short term would be administratively complicated and resource intensive'*.³⁰
30. Whilst acknowledging the challenges of monitoring modifications made to recreational vessels by owners, I repeat my recommendation 2 in those findings.

FINDING

I find that Adam James Vincent Pearson died from a cause consistent with drowning, in circumstances where he has accidentally fallen from his boat.

RECOMMENDATION

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

Recommendation 1

I recommend that Transport Safety Victoria continues to explore potential models for non-commercial vessel seaworthy inspection and certificate regime as a means of ensuring the seaworthiness of vessels at points of registration, transfer of ownership, and after any modification of the vessel.

²⁸ COR 2011 4499.

²⁹ COR 2011 4500.

³⁰ Submission from Maritime Safety Victoria to the Coroners Court of Victoria regarding the investigation into the death of James Sullivan, dated 6 February 2015.

I direct that a copy of this finding be provided to the following for their information only:

The family of Mr Pearson;
Investigating Member, Victoria Police;
Sergeant Adrian Sinclair, Victoria Police; and
Interested Parties.

I direct that a copy of this finding be provided to the following for their action:

Mr Peter Corcoran, Director, Maritime Safety, Transport Safety Victoria

Signature:



CAITLIN ENGLISH
CORONER
Date: 24 June 2016

